HCFA LEGISLATIVE SUMMARY

August 28, 1981

In the HCFA Legislative Summary of the Omnibus Budget Reconciliation Act of 1981 dated August 26, Section 2132 states that the Part A deductible for calendar year 1982 would equal $256. The actuaries now expect that the deductible will be higher. However, since the final figure will not be announced officially for another month, we have deleted the reference to the amount of the new deductible from the legislative summary. When final, this figure will be published in the Federal Register.

Attached is the revised page.

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and Policy

Attachment

HCFA LEGISLATIVE SUMMARY

August 26, 1981

On August 13, 1981, the President signed into law H.R. 3982, the "Omnibus Budget Reconciliation Act of 1981". This law (P.L. 97-35) includes many provisions affecting the Medicare, Medicaid, and PSRO programs. Summaries of changes having a direct impact on HCFA programs are attached.

Modifications to current law having an indirect effect on HCFA activities, such as AFDC eligibility changes, will be presented in a subsequent legislative summary.

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1981 HCFA LEGISLATIVE SUMMARY

Errata Sheet

Please note: the following corrections should be made in the HCFA Legislative Summary on Medicare and Medicaid Amendments of 1981. Corrections are underlined.

p. 12 REDUCTION IN MEDICAID PAYMENTS TO THE STATES (Section 2161)

Effective Date: October 1, 1981.

p. 14 COVERAGE OF, AND SERVICES FOR, THE MEDICALLY NEEDY (Section 2171)

Modification: (last line of second paragraph) If intermediate care facilities for the mentally retarded (ICF/MR) or services in mental institutions are covered for any group, then the currently mandatory services, or seven services from the entire list, must be covered for all medically needy groups.

p. 19 PERMITTING PHYSICIAN ASSISTANTS AND NURSE PRACTITIONERS TO PROVIDE CERTAIN RECERTIFICATIONS (Section 2183)

Modification: (third line)...Also, the time period for certifying and recertifying the need for care of individuals in intermediate care facilities for the mentally retarded (ICF/MR) is changed from 60 days to once a year.

MEDICARE AND MEDICAID AMENDMENTS OF 1981

MEDICARE AND MEDICAID AMENDMENTS OF 1981

PAYMENTS TO PROMOTE CLOSING AND CONVERSION OF UNDERUTILIZED HOSPITAL FACILITIES (Section 2101)

Current Law: There is no provision for reimbursing hospitals for closure or conversion of surplus beds.

Modification: This provision establishes under Medicaid State Plans and Medicare a "transitional allowance" for the closure, or conversion to approved use, of underutilized bed capacity or services. A hospital must have a determination made on whether it is eligible for the transitional allowance prior to undergoing actual closure or conversion.

The Secretary may include in a hospital's reasonable costs such a "transitional allowance" if he finds that the planned closure or conversion eliminates excess bed capacity, discontinues an underutilized service for which there are adequate alternatives or substitutes a needed service, and is consistent with findings of an appropriate health planning agency and with any applicable State program for reduction in the number of hospital beds in the State. In addition, if complete closure is contemplated, the hospital must be a private nonprofit or local government hospital and the closure cannot be for the purpose of replacing the existing plant. No more than 50 hospitals may be granted transitional allowances prior to January 1, 1984.

The Secretary is instructed to report to Congress by January 1, 1983, on the effectiveness of the transitional allowance program.

Effective Date: For services furnished during an accounting year beginning on or after October 1, 1981.

ADJUSTMENT IN PAYMENT FOR INAPPROPRIATE HOSPITAL SERVICES (Sections 2102) and 2173)

Current Law: When a beneficiary no longer requires acute hospital services, but must remain in the hospital because a medically necessary long-term bed is not available in the community, the hospital is to be reimbursed at a daily rate equal to the average Medicaid skilled nursing facility (SNF) or intermediate care facility (ICF) rate (whichever is appropriate for the level of care given). Those hospitals whose annual occupancy rate is equal to or greater than 80 percent are exempt from such reduced reimbursement and are paid at the acute-care rate.

Modification: The 80-percent exception from the differential reimbursement provision is eliminated. A non-public hospital's payments would be reduced by Medicare if the Secretary determines there is an "excess capacity" of beds either in the institution or the area. In the case of public hospitals, the determination of "excess capacity" will be based on other public hospitals in the area which are under common ownership with that hospital. State Medicaid Plans must also use reimbursement rates which reflect the level of care actually received.

Effective Date: Applies to services provided on or after September 1, 1981.

LIMITATION ON MEDICARE AND MEDICAID PAYMENTS FOR CERTAIN DRUGS (Section 2103)

Current Law: Under the 1962 amendments to the Federal Food, Drug, and Cosmetic Act (FFDCA) drugs are required to be determined effective as well as safe before they can be approved by the Food and Drug Administration (FDA) for marketing. Drugs cannot be utilized under the Medicare and Medicaid programs unless they have been approved by the FDA. Thus, reimbursement would be discontinued for a drug if FDA makes a final determination (following opportunity for a hearing) not to approve the drug. Of course, since coverage of prescription drugs is a State option under Medicaid, reimbursement of specific drugs approved by FDA varies from State to State.

Modification: The provision prohibits Medicare part B and Medicaid reimbursement for those prescription drugs which were approved prior to the 1962 amendments to the FFDCA and subsequently are determined to be less than effective in use. Payment would be discontinued at the time that the Secretary proposes an order to withdraw approval of the drug and issues a notice of an opportunity for a hearing. If a drug is subsequently proven to be effective, reimbursement would then be allowed.

Effective Date: October 1, 1981.

WITHHOLDING OF PAYMENTS FOR CERTAIN MEDICAID PROVIDERS (Section 2104)

Current Law: The Secretary is authorized to withhold Medicaid payments to institutional and individual providers to offset overpayments made to them under the Medicare program. No similar provision exists for Medicaid overpayments.

Modification: The Secretary has authority to withhold payments due to Medicare providers to offset Medicaid overpayments. The Secretary would then reimburse State Medicaid agencies from the amount recovered. This provision is intended to be used in cases where the Medicare provider has terminated or substantially reduced participation in Medicaid.

Effective Date: Upon enactment.

CIVIL MONETARY PENALTIES (Section 2105)

Current Law: The Secretary has no authority to impose civil money penalties in cases of Medicare and Medicaid fraud. The Secretary does have authority to exclude practitioners and providers from participation in Medicare and Medicaid for certain improper practices.

Modification: The bill gives the Secretary authority to assess penalties against Medicare and Medicaid practitioners and providers for fraudulent practices. Specifically, the Secretary can impose a civil penalty of up to $2000 for each fraudulently claimed item or service, impose an assessment of up to twice the amount of the fraudulent portion of the claim in lieu of damages, and deny participation in Medicare and Medicaid to persons filing fraudulent claims. Persons subject to a monetary penalty would be given written notice and an opportunity for an administrative hearing, prior to imposition of the penalty.

This provision also includes a technical provision deleting duplicative language in section 1128(a)(1) regarding the time period of exclusion.

Effective Date: Upon enactment.

TECHNICAL CORRECTION OF ERROR MADE BY THE MEDICARE AND MEDICAID AMENDMENTS OF 1980 (Section 2106)

Current Law: The 1980 Reconciliation Act deleted a provision of prior law which limited Medicare part B reimbursement to the lower of the provider's customary charge or the reasonable cost of the covered service.

Modification: This provision restores the provision of prior law that was erroneously deleted.

Effective Date: December 5, 1980.

MAKING DELEGATED REVIEW OPTIONAL (Section 2111)

Current Law: Current statutory provisions require Professional Standards Review Organizations (PSROs) to delegate the performance of review functions to hospitals which are willing and found by the PSRO to be capable of performing review.

Modification: PSROs will now have the discretion to choose which hospitals should be delegated review functions.

Effective Date: Upon enactment.

ASSESSMENT OF PSRO PERFORMANCE (Section 2112)

Current Law: Existing statutory provisions require that the National Professional Standards Review Council review the operations of PSROs to determine their effectiveness and comparative performance. The Secretary also evaluates whether a PSRO is substantially carrying out its duties in a satisfactory manner for the purposes of moving the organization from conditional to full designation or of terminating a PSRO.

Agreements with fully designated PSROs must be for a period of 12 months and can be terminated upon prior notice as prescribed in regulations, after opportunity for a formal hearing is provided. Judicial review of a termination action is not addressed.

The Secretary is required to establish a program to evaluate the cost-effectiveness of certain types of review. In implementing this program the Secretary must require that certain PSROs perform review of particular health care services to establish the cost-effectiveness of the review. If cost-effectiveness is demonstrated, the Secretary must require qualified PSROs to perform such review.

Modification: In addition to existing provisions, the Secretary is required to specify PSRO requirements relative to monitoring the quality of care, reducing unnecessary utilization and managing activities efficiently and to assess all PSROs' performances based on these requirements. The Secretary

may refuse to renew agreements with PSROs found to be ineffective or inefficient, except that not more than 30 percent of the PSROs in existence on May 1, 1981 may be terminated during FY 1982.

The Secretary is given the discretion to enter into agreements with fully designated PSROs for less than 12 months. Fully designated PSROs must receive a 90-day notice of impending termination and will no longer have the opportunity for a formal hearing if their agreements were entered into after this provision's enactment. Termination actions are specifically precluded from judicial review. The Secretary is required to report to Congress the results of the PSRO assessment and any determinations made not to renew PSRO agreements on the basis of performance.

The Secretary may, at his discretion, require PSROs to review particular health care services when evaluation demonstrates such review is cost-effective or yields other significant benefits.

Effective Dates:

- Specification of performance assessment requirements and assessment of PSRO performance - September 30, 1981.

- Report to Congress on assessments and terminations - September 30, 1982.

All other provisions in this section are effective upon enactment.

OPTIONAL USE OF PSROS UNDER STATE MEDICAID PLANS (Section 2113)

Current Law: PSROs are required to review health care services provided to Medicare, Medicaid, and Maternal and Child Health patients under Titles XVIII, XIX, and V of the Social Security Act. The cost of this review is paid entirely by Federal funds. PSROs review Medicaid patients according to administrative arrangements in a Memorandum of Understanding required to be negotiated with a State before the implementation of Medicaid review.

Modification: PSROs are required to review only those health care services provided to Medicare patients. States will be deemed to meet State Title XIX plan requirements for utilization and medical review if they contract with PSROs for review services not inconsistent with the PSROs' mandated review functions and the contract contains assurances of satisfactory performance required by the Secretary. Federal funds will support 75 percent of a State's costs attributable to PSRO review of Medicaid services.

Effective Date: Applies to agreements entered into on or after October 1, 1981.

SECRETARIAL DETERMINATION IN LIEU OF PSRO CERTIFICATION (Section 2114)

Current Law: PSROs (or, in the absence of a qualified PSRO, alternate organizations with review responsibility under the PSRO statute) must determine whether a Medicare patient requires a hospital level of care and,

if not, whether SNF services are available. If the PSRO certifies that post-hospital extended care services are necessary but unavailable, the hospital will be reimbursed for continued inpatient care at a rate paid for lower level of care services.

Modification: In areas not served by PSROs, the Secretary or his designated agent will determine the level of care and availability of SNF care for the purpose of making differential reimbursement to hospitals.

Efective Date: Upon enactment.

ELIMINATION OF PART A COVERAGE OF ALCOHOL DETOXIFICATION FACILITY SERVICES (Section 2121)

Current Law: Effective April 1, 1981, payment is authorized under part A of Medicare for inpatient detoxification services provided in a free-standing facility. The Secretary is also charged with undertaking a number of studies and demonstration projects related to alcohol and drug detoxification and rehabilitation.

Modification: The provision repeals the coverage of inpatient services provided in free-standing alcohol detoxification facilities. It also repeals the requirement for certain studies and demonstration projects.

Effective Date: Applies to inpatient stays beginning the 10th day after enactment.

ELIMINATION OF OCCUPATIONAL THERAPY AS A BASIS FOR INITIAL ENTITLEMENT TO HOME HEALTH SERVICES (Section 2122)

Current Law: Effective July 1, 1981, the need for occupational therapy services was established as one of the qualifying services for Medicare home health coverage; e.g., if a patient who is homebound and certified by a physician to need care is in need of the services of an occupational therapist, he/she is also entitled to the full range of Medicare home health services.

Modification: Under this provision, the need for occupational therapy alone would not be enough to establish a patient's need for home health services. However, in those situations where a course of home health treatment had been instituted, because a patient needed skilled nursing care or physical or speech therapy, home health services would be continued even though the patient no longer required any skilled service other than occupational therapy.

Effective Date: For plans of treatment established beginning December 1, 1981.

MAKING PART A COINSURANCE CURRENT WITH THE YEAR IN WHICH SERVICES FURNISHED (Section 2131)

Current Law: Part A coinsurance is imposed after the 60th day of covered hospital care in a spell of illness, for lifetime reserve days, and for SNF days beyond the 20th day in a spell of illness. Such coinsurance is a fraction of the deductible which is in effect for the year in which the spell of illness began. Where a beneficiary experiences a spell of illness which overlaps two or more calendar years, the coinsurance reflects the deductible in effect at the beginning of the period.

Modification: Part A coinsurance is based on the deductible for the calendar year in which services are received rather than the deductible in effect at the time the beneficiary's spell of illness began.

Effective Date: January 1, 1982.

MAKING PART A COINSURANCE AND DEDUCTIBLE MORE CURRENT (Section 2132)

Current Law: A beneficiary is required to meet a deductible which is intended to cover the cost of one day of inpatient hospital care in a spell of illness. The part A deductible ($204 for calendar year 1981) is mathematically derived through a formula using a base figure of $40. Coinsurance rges are imposed for additional covered inpatient services. Such charges a fraction of the basic deductible amount.

Modification: This provision raises to $45 the base of the formula that is used in the determination of the part A deductible. For calendar year 1982, the deductible will equal $256 instead of $228. Coinsurance amounts will be figured on this new amount.

Effective Date: January 1, 1982.

ELIMINATION OF CARRYOVER FROM PREVIOUS YEAR OF INCURRED EXPENSES FOR MEETING THE PART B DEDUCTIBLE (Section 2133)

Current Law: Beneficiaries are allowed to "carry-over" medical expenses incurred in the final quarter of a calendar year (and applied to the deductible for that year) into the following year to meet part B deductible requirements for that year. The effect is that unreimbursed covered expenses in the current calendar year, plus those incurred in the last 3 months of the preceding year, are considered in determining whether an individual has met the deductible.

Modification: Medical expenses incurred in the last 3 months of the preceding year will be excluded in determining whether an individual has satisfied the part B deductible in the current calendar year. Thus, expenses applied toward the deductible in any one calendar year must have incurred in that year.

Effective Date: January 1, 1982 (for expenses incurred on or after October 1, 1981).

INCREASE IN PART B DEDUCTIBLE (Section 2134)

Current Law: Under the supplementary medical insurance program, Medicare beneficiaries are generally required to incur $60 in expenses for covered medical services in a calendar year before the program will begin making payments.

Modification: This provision increases the $60 deductible to $75.

Effective Date: January 1, 1982.

LIMITATION ON ROUTINE NURSING DIFFERENTIAL (Section 2141)

Current Law: In determining reasonable costs for inpatient routine hospital services under Medicare, the Secretary, by regulation, includes in reimbursement an additional 8.5 percent of inpatient routine nursing salary costs.

Modification: The routine nursing salary cost differential is reduced from 8.5 percent to 5 percent. This provision requires the Comptroller General to conduct a study to determine the extent to which higher payments are justified and report back to the Congress within 6 months after enactment (February 1982).

Effective Date: Applies to cost reporting periods ending after September 30, 1981; however, in the case of a cost reporting period beginning before October 1, 1981, the reduction in payments will be applied only to that portion of the reporting period occurring after September 30, 1981.

LIMITATION ON REASONABLE COST AND REASONABLE CHARGE FOR OUTPATIENT SERVICES (Section 2142)

Current Law: Medicare recognizes no upper limit on reasonable costs or charges for outpatient services furnished by hospitals, community health centers, and clinics.

Modification: The Secretary is required to establish, by regulation, to the extent feasible, limitations on costs or charges that will be considered reasonable for outpatient services provided by hospitals, community health centers, or clinics and by physicians utilizing these facilities. Actual charges will be used in developing the limitations, which are to be reasonably related to the charges in the same area for similar services provided in physicians' offices. The limitations do not apply with respect to bona fide hospital emergency room services. The Secretary may also provide exceptions to these limitations in cases where similar services are not generally available in physicians' offices in the area.

Effective Date: Upon enactment, subject to future regulations.

LIMITS ON REIMBURSEMENT TO HOSPITALS (Section 2143)

Current Law: In determining the reasonable costs of services furnished to Medicare patients, the Secretary has established a schedule of reimbursement limits on hospital inpatient routine operating costs which is updated periodically. The limits under the methodology currently in use are on a per diem basis and are set at 112 percent of the mean costs of each comparison group of hospitals.

Modification: This provision reduces Medicare reimbursement limits currently applied to hospital inpatient routine operating costs from 112 to 108 percent of the mean or such other comparable or lower limits as the Secretary may determine. The Secretary may provide for exemptions and exceptions to this limitation as he deems appropriate.

Effective Date: Applies to cost reporting periods ending after September 30, 1981; however, in the case of a cost reporting period beginning before October 1, 1981, the lower limit will be applied only to that portion of the reporting period occurring after September 30, 1981.

LIMITS ON REIMBURSEMENT TO HOME HEALTH AGENCIES (Section 2144)

Current Law: In determining the reasonable costs of home health services for Medicare beneficiaries, the Secretary has established a schedule of reimbursement limits for home health agencies which is updated periodically. The limits are set at the 80th percentile of the average cost per visit and calculated by type of service (e.g., skilled nursing, home health aide). However, the limits are applied in the aggregate to each home health agency's costs based on the agency's total number of visits for all types of services.

Modification: This provision reduces the Medicare reimbursement limits applied to home health agency costs from the 80th to the 75th percentile, or such comparable or lower limit as the Secretary may determine. The Secretary may provide for exemptions and exceptions to this limitation as he deems appropriate.

Effective Date: Applies to cost reporting periods ending after September 30, 1981; however, in the case of a cost reporting period beginning before October 1, 1981, the lower limit will be applied only to that portion of a reporting period occurring after September 30, 1981.

INCENTIVE REIMBURSEMENT RATE FOR RENAL DIALYSIS SERVICES (Section 2145)

Current Law: Hospital-based dialysis facilities are paid 80 percent of their reasonable costs up to a national payment screen, and free-standing facilities are paid 80 percent of their reasonable charges up to the same screen. Facilities providing home dialysis may elect to be paid either a prospectively set target rate or Medicare reasonable costs or charges, as appropriate.

Modification: The new provision requires the Secretary to provide a method or methods for determining prospective reimbursement rate(s) for each mode of dialysis furnished in the hospital-based or free-standing facility or at home. The method(s) would incorporate separate composite weighted formulae for the two types of facilities.

However, if the Secretary determines, after detailed analysis, that another method (or methods) of determining prospectively the amounts of payments to be made for dialysis services would more effectively encourage the more efficient delivery of dialysis and would provide greater incentives for increased use of less costly home dialysis than the dual composite weighted formula, the Secretary may use that other method. The method(s) adopted must differentiate between hospital-based and free-standing facilities, and encourage home dialysis.

Effective Date: On or after October 1, 1981 (including promulgation of regulations by this date).

MEDICARE PAYMENTS SECONDARY IN CASES OF END-STAGE RENAL DISEASE SERVICES COVERED UNDER CERTAIN GROUP HEALTH POLICIES (Section 2146)

Current Law: Medicare is the primary payor for end-stage renal disease (ESRD) benefits, and almost all people with permanent kidney failure who need renal dialysis treatment or a kidney transplant are eligible for Medicare coverage.

Modification: This provision:

(1) Makes Medicare the secondary payor for the first 12 months after an individual, who has private group health insurance coverage, is eligible for Medicare ESRD benefits. Ultimately, Medicare would reimburse only its share of those covered costs not covered by the private plan. Any Medicare payment (on an interim basis) for services during this period would be conditional on reimbursement to the program when payment is made by the plan.

(2) Does not allow as a tax deduction the expenses paid or incurred by an employer for a group health plan if the plan differentiates in the benefits it provides between individuals having end-stage renal disease and other individuals covered by the plan.

This provision would apply only where the renal patient is under age 65 and not entitled to Medicare because of receipt of social security disability benefits.

Effective Date: (1) October 1, 1981; (2) January 1, 1982.

ELIMINATION OF UNLIMITED OPEN ENROLLMENT (Section 2151)

Current Law: An individual may enroll in part B of the Medicare program during an initial enrollment period (which begins with the third month before the month in which the individual becomes age 65 and extends for 7 months). If an individual fails to enroll during his or her initial enrollment period, enrollment is possible during a continuous open enrollment period. Entitlement under the open enrollment period begins on the third calendar month following the month of enrollment.

Modification: This provision repeals Medicare part B continuous open enrollment and reinstitutes the general enrollment period which occurs January 1 through March 31 of each year. Coverage then becomes effective on July 1.

Effective Date: October 1, 1981.

UTILIZATION GUIDELINES FOR PROVISION OF HOME HEALTH SERVICES (Section 2152)

Current Law: As a condition of payment for home health services, a physician must certify that the services are required because the patient is homebound and needs intermittent skilled nursing care, physical therapy, or speech therapy, or, as of July 1, occupational therapy. In addition, the physician must establish and periodically review a plan of care. There are no direct requirements for guidelines for intermediaries.

Modification: Under this provision, the Secretary is required to establish utilization guidelines and issue instructions for Medicare intermediaries to establish a program for reviewing claims on a sample basis to monitor whether the claims meet Medicare coverage criteria.

Effective Date: October 1, 1981.

REPEAL OF STATUTORY TIME LIMITATION ON AGREEMENTS WITH SKILLED NURSING FACILITIES (Section 2153)

Current Law: SNF provider agreements are renewed on an annual basis. In order to renew an agreement, a SNF must undergo a survey and certification process to confirm its compliance with applicable health and safety requirements.

Modification: The 12-month statutory limitation on agreements with SNFs is repealed.

Effective Date: Upon enactment.

REMOVAL OF LIMITATION ON NUMBER OF MEDICARE DEMONSTRATION PROJECTS (Section 2154)

Current Law: The Secretary has authority to approve the use of alternative Medicare reimbursement rates or methods in a State in connection with a demonstration project on containing rising hospital costs. The Secretary is required to continue to reimburse hospitals in accordance with the system used in a State cost containment demonstration when the demonstration ends, provided the State program meets certain tests of effectiveness in controlling costs and the State elects to continue the reimbursement system. No more than six Statewide demonstration projects can be continued or implemented under this authority.

Modification: The provision of current law limiting to six the number of Statewide Medicare hospital reimbursement demonstration projects is repealed.

Effective Date: Upon enactment.

REPEAL OF TEMPORARY DELAY IN PERIODIC INTERIM PAYMENTS (Section 2155)

Current Law: A one-time deferral of the Periodic Interim Payment (PIP) method of reimbursement to hospitals for the last 3 weeks of FY 1981 is authorized.

Modification: This provision repeals the deferral of PIP.

Effective Date: Upon enactment.

STATUTORY DEADLINES FOR IMPLEMENTING AFDC HOME HEALTH AIDE DEMONSTRATION PROJECTS (Section 2156)

Current Law: The Secretary is required to enter into agreements with up to 12 States, selected at his discretion, for the purpose of conducting demonstration projects for the training and employment of Aid to Families with Dependent Children (AFDC) recipients as homemakers and home health aides. No specific implementation date is included in the law.

Modification: Under this provision, the Secretary is required to establish, by October 1, 1981, such guidelines and regulations as are necessary to assure that agreements with States are entered into not later than January 1, 1982, for the training of AFDC recipients as homemakers and home health aides. This provision requires a report to Congress during January 1982 on current and anticipated progress, including a description of the agreements entered into by that time and a timetable for the conclusion of any other agreements that the Secretary anticipates.

Effective Date: Upon enactment.

REDUCTION IN MEDICAID PAYMENTS TO THE STATES (Section 2161)

Current Law: Generally, State Medicaid program expenditures are matched by the Federal government at a percentage rate which varies from State to State according to a statutory formula. There are several categories of expenditures which are reimbursed at specific percentage rates for all States.

Modification: The Federal government continues to match State expenditures at the matching rates set in current law. The total Federal reimbursement each State receives in FY 1982, FY 1983, and FY 1984, however, will be reduced by 3 percent, 4 percent, and 4.5 percent respectively. The level of each State's reduction could be lowered by one percentage point for each of the following three conditions: operation of a qualified hospital cost review program; an unemployment rate exceeding 150 percent of the national average; and fraud and abuse recoveries (including third party liability recoveries in FY 1982) equal to one percent of Federal payments to the State.

A qualified hospital cost review program must (1) be established by statute, (2) be operated by the State, (3) apply to all non-Federal hospitals, (4) review all non-Medicare inpatient revenues or expenses, or at least 75 percent of all revenues and expenses including those under Medicare, (5) provide substantially equal treatment to all payors, and (6) show that its annual rate of increase in aggregate hospital costs per capita or per admission is at least 2 percentage points lower than the rate of inflation in all States without qualifying programs.

In addition, States can decrease their reductions by spending less than their "target" amount. Each State's target amount for FY 1982 will be 109 percent of the State's estimate of the Federal share of its FY 1981 spending as received by the Secretary before April 1, 1981. Target amounts for FY 1983 and FY 1984 will be increased or decreased based on changes in the medical care component of the consumer price index. For each dollar less than its target amount the State spends, a dollar is offset from its total reduction.

The modification in reimbursement established under this section applies only to existing Medicaid programs, except for Puerto Rico and the Territories.

Effective Date: October 1, 1982 - The bill specifies, however, that no reductions can be made for a quarter unless, as of the first day of the quarter, final regulations (on an interim or other basis) have been promulgated and are in effect to implement amendments to the requirements for coverage and benefits of the medically needy, amendments regarding hospital reimbursement, and amendments (from the 1980 Reconciliation bill) related to SNF and ICF reimbursement. The provisions of this section are repealed in FY 1985.

PAYMENTS TO TERRITORIES (Section 2162)

Current Law: Federal Medicaid payments to the Territories cannot exceed $30 million for Puerto Rico, $1 million for the Virgin Islands, and $900,000 for Guam.

Modification: This section increases the Territories' ceilings to $45 million for Puerto Rico, $1.5 million for the Virgin Islands, and $1.4 million for Guam. It establishes a ceiling of $350,000 for the Northern Mariana Islands.

Effective Date: Fiscal years beginning with fiscal year 1982.

ELIMINATING TIME PERIOD LIMITATION ON PAYMENT OF INTEREST ON DISPUTED CLAIMS (Section 2163)

Current Law: A State may retain Federal matching funds for claims which are disallowed while its administrative appeal of the disallowance is pending. If it loses its appeal, it must pay interest on the funds retained. There is a time limit on interest liability of 12 months for disallowances made prior to October 1, 1980, and 6 months for disallowances made thereafter. The rate of interest to be returned is determined by the Secretary, based on the average of the bond equivalent of the weekly 90-day Treasury bill auction rates during the period the State kept the funds.

dification: This provision deletes the time limit on the period for ch the State must pay interest.

Effective Date: Upon enactment.

ELIMINATING FEDERAL MATCHING FOR CERTAIN LABORATORY TESTS (Section 2164)

Current Law: Federal matching payments may not be made for State Medicaid expenditures under a number of circumstances set forth in the law.

Modification: This provision additionally prohibits Federal matching payments for inpatient hospital tests furnished to Medicaid eligibles unless such tests are specifically ordered by the attending physician or other responsible practitioner (except in emergency situations).

Effective Date: Applies to tests occurring on or after October 1, 1981.

STUDY OF FEDERAL MEDICAL ASSISTANCE PERCENTAGE FORMULA AND OF ADJUSTMENTS OF TARGET AMOUNTS FOR FEDERAL MEDICAID EXPENDITURES (Section 2165)

Current Law: The present formula for determining the Federal share of a State's payments for Medicaid services is based on the State's per capita income. By design, the formula provides a higher percentage of Federal matching funds to States with low per capita incomes (up to a statutory maximum of 83 percent) and a lower percentage of Federal matching funds to States with high per capita incomes (down to a minimum of 50 percent).

Modification: The Comptroller General, in consultation with the Advisory Committee for Intergovernmental Relations, shall conduct a study of the current Medicaid matching formula and the validity and equity of an adjustment to the target amounts (established in Section 2161) to reflect economic and demographic factors not within the effective control of the States. The following factors and how they differ between States will be examined in the study: the feasibility and consequence of revising the formula to take into account States' relative economic positions and needs; the amounts of support and income payments made by the States under the Social Security Act; the relative cost of living and unemployment rates in States; the relative taxable wealth and amount of taxes raised per capita by States; and other relevant factors bearing on an equitable distribution of Federal funds to States under the Social Security Act.

Effective Date: Upon enactment. The Comptroller General shall report to Congress on the study no later than October 1, 1982.

COVERAGE OF, AND SERVICES FOR, THE MEDICALLY NEEDY (Section 2171)

Current Law: States have the option of extending eligibility for Medicaid to the medically needy. These are individuals who meet the categorical eligibility standards, i.e., they are aged, blind, disabled or members of families with dependent children, and have too much income to qualify for cash assistance under AFDC or Supplemental Security Income, but not enough income to afford medical care. If a State chooses to cover the medically needy, it must cover all medically needy groups; provide services that are comparable in amount, duration and scope to all such groups; and offer a minimum number of services, including a mix of institutional and non-institutional services.

Modification: This provision repeals all coverage and service requirements with respect to the medically needy (except that States would continue to be required to offer home health services to any person eligible for SNF care).

If a State decides to cover any medically needy groups, certain new minimum requirements would apply: (1) The State must provide ambulatory services to children and prenatal and delivery services for pregnant women; (2) Groups covered for institutional services must be covered for ambulatory services; and (3) If Intermediate Care Facilities for the Mentally Retarded (ICF/MR) or psychiatric hospital services are covered for any group, then the currently mandatory services, or seven services from the entire list, must also be covered for that group.

A State must include in the State Plan a description of the criteria for determining eligibility of individuals in covered medically needy groups, and the amount, duration and scope of services made available to individuals in the group. (Nothing in this section, however, would allow the State to cover individuals not covered under current law.)

Effective Date: Upon enactment.

FLEXIBILITY IN COVERAGE OF INDIVIDUALS AGED 18-20 (Section 2172)

Current Law: States that elect to include students aged 18 through 20 under their AFDC programs must provide Medicaid coverage to any individual under 21 who would be eligible for AFDC if he or she were a student.

If a State extends Medicaid to certain non-AFDC low income children it must cover all such children under age 21, or reasonable categories (based on factors other than age) of these children.

Modification: States that elect to include students aged 18 through 20 under AFDC are not required to provide Medicaid coverage to persons under 21 who would be eligible for AFDC if attending school; coverage of these individuals is optional.

States which choose to provide Medicaid coverage to children who are not receiving AFDC may limit such coverage to children under 21, 20, 19 or 18, or any reasonable category of such children.

Effective Date: Upon enactment.

REIMBURSEMENT OF HOSPITALS (Section 2173)

Current Law: State Medicaid programs are required to pay for inpatient hospital services on a Medicare reasonable cost basis unless an alternate reimbursement method has been approved by the Secretary.

Modification: The current law provision for "reasonable cost" reimbursement is replaced by a new requirement. The States must make assurances satisfactory to the Secretary that the rates paid hospitals are "reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities" to provide care in accordance with applicable laws and quality and safety standards. The rates paid must take into account the unusual costs incurred by hospitals, especially public and teaching hospitals, serving large numbers of low income patients. States must also assure that the rates paid provide reasonable access to inpatient hospital services of adequate quality. Further, States must provide assurances, satisfactory to the Secretary, for the filing of uniform cost reports by each hospital and periodic audits by the States of such reports.

The Secretary is required to develop a model prospective payment methodology for inpatient hospital costs which could be used under both the Medicare and the Medicaid programs. The Secretary must report on the progress of the system's development by July 31, 1982.

NOTE: The summary of Section 2102 includes a discussion of a change in Medicaid reimbursement based on appropriateness of level of care.

Effective Date: Applies to services furnished on or after the date final regulations (including interim final regulations) are promulgated to carry out this section.

REMOVAL OF MEDICAID REASONABLE CHARGE LIMITATION (Section 2174)

Current Law: State Medicaid payments for physicians' services and certain medical supplies and laboratory services cannot exceed reasonable charge levels established under Medicare. In addition, State Plans must provide for methods and procedures to assure that payments under the State Plan are not in excess of reasonable charges.

Modification: This provision repeals the reasonable charge limit requirement, as well as the requirement that State Plans provide for methods and procedures to assure that payments are not in excess of reasonable charges.

Effective Date: Effective for services furnished on or after October 1, 1981.

INAPPLICABILITY AND WAIVER OF FREEDOM-OF-CHOICE AND OTHER STATE PLAN REQUIREMENTS (Section 2175)

Current Law: Medicaid eligibles are currently free to choose from among any of the providers, practitioners, and suppliers of health services that are covered by a State's Medicaid program. The Secretary is authorized to waive any Federal Medicaid requirements to enable a State to conduct an experimental, pilot, or demonstration project, including prospective reimbursement demonstrations. No time limit is set on Secretarial action on a State waiver request.

Modification: This section provides that a State shall not be held out of compliance for failure to meet certain State Plan requirements (e.g. statewideness, freedom-of-choice) if it purchases laboratory services and medical devices through a competitive bidding process or other arrangement, and the Secretary finds that adequate services or devices will be available to beneficiaries. Laboratories selected to provide services must meet applicable sections of the Medicare quality standards for laboratories and any additional requirements specified by the Secretary, and can do no more than 75% of their total business with Medicaid and Medicare.

States (or their political subdivisions) are also not to be held out of compliance (1) if they contract with organizations which agree to provide care and services in addition to those offered under the State Plan to eligible individuals residing in the area served by the organization and who elect to receive care from the organization, or (2) if they only pay for rural health clinic services which are provided by a rural health clinic.

States also will not be held out of compliance if they "lock-in" beneficiaries who overutilize services to a particular provider for a reasonable time period. A State may also "lock-out" from participation for a reasonable period providers who abuse the program. A State may impose these restrictions following notice and opportunity for a hearing in accordance with State-established procedures, provided that, under such restrictions, eligible individuals have reasonable access to services of adequate quality.

The Secretary is authorized to waive certain Federal requirements to the extent that he finds it to be cost-effective, efficient and not inconsistent with program intent for a State (1) to implement a primary care case management system or a physician specialty arrangement, (2) to allow a locality to act as a central broker in assisting Medicaid beneficiaries in selecting among competing health plans, (3) to share with recipients (in the form of additional services) savings resulting from use of more cost-effective care, and (4) to restrict the provider from whom the beneficiary can obtain services (in other than emergency circumstances). Providers must comply with State standards which are consistent with access, quality, efficient and economic provision of services, and non-discrimination among classes of providers.

No waiver granted by the Secretary under this section may extend beyond two years unless the State requests a continuation. A continuation will be deemed granted unless the Secretary denies the State's request in writing within 90 days after the date of its submission to the Secretary.

The Secretary must monitor waivers granted to assure compliance and terminate any waiver where, after notice and opportunity for a hearing, he finds non-compliance.

Secretarial report to Congress on waivers granted under this section is required by September 30, 1984.

Effective Date: Effective for calendar quarters beginning on or after October 1, 1981, except that where the Secretary determines that additional

State legislation is required for the State plan to meet the standards that apply to the provision of laboratory services under this section, the State will not be considered to be out of compliance until January 1 of the year after the close of the first regular session of the State legislature that begins after the date of enactment.

WAIVER TO PROVIDE HOME AND COMMUNITY-BASED SERVICES FOR CERTAIN INDIVIDUALS (Section 2176)

Current Law: Federal matching is only available under Medicaid for "medical assistance", that is, for services which are primarily medical in nature.

Modification: The Secretary may by waiver allow a State to include under its plan approved home- or community-based services, except for room and board, to individuals who, without these services, would require care in a SNF or ICF which would be paid for under the State Plan. States may include case management services, homemaker/home health aide services and personal care services, adult day health, habilitation services, respite care, and other services requested by the State which the Secretary approves. Such services must be provided pursuant to a written plan of care.

In order to receive a waiver, States must provide assurances that: 1) necessary safeguards have been taken pertaining to beneficiaries' health and welfare and to financial accountability for funds expended on these services; 2) they will provide for an evaluation of the need for such services with respect to those entitled to SNF or ICF care; 3) individuals determined likely to require SNF or ICF care are informed of these alternative services; 4) the estimated average per capita expenditure for all services provided individuals under this waiver would not exceed what would have been spent for those persons without the waiver; and 5) they will provide information annually to the Secretary on the impact of the waiver.

In connection with waivers under this section, the Secretary also may grant waivers of the requirements that services be provided Statewide and that services for comparable groups must be the same in amount, duration, and scope. Waivers will be initially granted for a three-year period, and may be extended for additional three-year periods, upon State request, unless the Secretary determines that the State's assurances have not been met.

Effective Date: 90 days after the date of enactment.

TIME LIMITATION FOR ACTION ON REQUESTS FOR PLAN AMENDMENTS AND WAIVERS (Section 2177)

Current Law: State Medicaid Plans, plan amendments, and waivers must be approved by the Secretary of HHS; however, no time limit is required for Secretarial action.

Modification: This provision sets a time limit of 90 days for the Secretary to act on requests for proposed Medicaid Plans, plan amendments, and waivers. A request shall be deemed granted unless the Secretary, within 90 days

..ter the date of submission, either denies such request in writing or requests further information. The Secretary has 90 days to act after the date additional information is received.

Effective Date: 90 days after the date of enactment.

FLEXIBILITY IN PREPAID PROVIDER (HMO) PARTICIPATION IN STATE PLANS (Section 2178)

Current Law: States may only have prepaid risk contracts with federally qualified HMOs. Contracting HMOs must generally have an enrollment that consists of less than 50 percent Medicaid and Medicare beneficiaries.

Modification: In addition to qualified HMOs, States may have prepaid risk contracts with organizations which 1) make covered services accessible to Medicaid enrollees to the same extent that these services are accessible to beneficiaries not enrolled with the organization, and 2) have made adequate provision against the risk of insolvency. The HMOs must assure that Medicaid enrollees will not be held liable for debts in the event of their insolvency. The enrollment limit for Medicare and Medicaid beneficiaries is increased to 75 percent. The Secretary may modify or waive this requirement for public HMOs where warranted by special circumstances and where the HMO is making reasonable efforts to enroll the private sector.

..ntracts between States and prepaid entities must provide for Secretarial ..d State access to certain books and records of the HMO; non-discrimination on the basis of health status or use of health services in the entity's enrollment, reenrollment and disenrollment activities; rights to disenrollment for individuals after one full month of membership; and reimbursement for medically necessary emergency services received out-of-plan. Payments to prepaid plans must be made on an actuarially sound basis.

States may guarantee Medicaid eligibility for up to six months for individuals enrolled in qualified HMOs but only for purposes of their enrollment in the HMO.

The Secretary shall study the termination of HMO membership by Medicaid beneficiaries, placing particular emphasis on the quantity and quality of care in the HMO and the quality of care in the fee-for-service sector. An interim report is due in two years, and a final report, in five years.

Effective Date: Effective for services furnished on or after October 1, 1981. For contracts entered into before that date, the amendments shall not apply unless the HMO, the State, and the Secretary agree.

REPEAL OF EPSDT PENALTY (Section 2181)

Current Law: Existing provisions require a one percent reduction in ..deral matching payments to States under their AFDC program for failure to inform AFDC families of the availability of Early and Periodic Screening, ..iagnosis and Treatment (EPSDT) services under Medicaid, 2) provide or arrange for screening services when requested, or 3) arrange for corrective treatment of conditions identified by child health screening services.

Modification: The AFDC penalty provisions are repealed. State Title XIX Plans are required to provide for informing all Medicaid eligibles under 21 of the availability of EPSDT services and for arranging for screening and treatment services.

Efective Dates:

- Repeal of AFDC penalty - June 30, 1974.

- State Title XIX Plan requirements - October 1, 1981.

FLEXIBILITY IN REQUIRING COLLECTION OF THIRD PARTY PAYMENTS (Section 2182)

Current Law: States are required to recover payments due for services provided to a Medicaid eligible with private insurance or other third party coverage.

Modification: States need not collect third party liabilities in cases where the amount the State can reasonably be expected to collect is less than the costs of recovery.

Effective Date: Upon enactment.

PERMITTING PHYSICIAN ASSISTANTS AND NURSE PRACTITIONERS TO PROVIDE CERTAIN RECERTIFICATIONS (Section 2183)

Current Law: States are subject to a fiscal penalty unless physicians certify and recertify every 60 days the need for institutional services for Medicaid eligibles in a hospital, SNF or ICF.

Modification: States may use physician assistants and nurse practitioners (within the scope of their practice under State law) supervised by a physician to recertify the need for care. Also, the time period for certifying and recertifying the need for care of individuals in ICFs is changed from every 60 days to once a year.

Effective Date: Effective for payments made to States for calendar quarters beginning on or after October 1, 1981.

REPEAL OF OBSOLETE AUTHORITY FOR MEDICAL ASSISTANCE (Section 2184)

Current Law: Titles I, IV, X, XIV and XVI contain provisions relating to Federal funding of financial and medical assistance to certain groups.

Modification: This provision deletes references to obsolete authority for Medical Assistance from Titles I (Grants to States for Old Age Assistance and Medical Assistance for the Aged), IV (Grants to States for Aid and Services to Needy Families with Children and For Child Welfare Services), X (Grants to States for Aid for the Blind), XIV (Grants to States for Aid to the Permanently and Totally Disabled), and XVI (Grants to States for Aid to

the Aged, Blind and Disabled, or for Such Aid and Medical Assistance for the Aged). The provision also clarifies that the financial assistance sections of Titles I, X, XIV and old XVI now apply only to Puerto Rico, Guam, and the Virgin Islands. The medical assistance authority in these titles became obsolete with the enactment of Title XIX.

Effective Date: Upon enactment.